Complete Summary

GUIDELINE TITLE

Screening and interventions for overweight in children and adolescents: recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force (USPSTF). Screening and interventions for overweight in children and adolescents: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2005. 11 p. [39 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Overweight

Note: Being at risk for overweight is defined as a body mass index (BMI) between the 85th and 94th percentile for age and sex, and overweight as a BMI at or above the 95th percentile for age and sex.

GUIDELINE CATEGORY

Prevention
Screening

CLINICAL SPECIALTY

Family Practice
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Dietitians
Health Care Providers
Health Plans
Managed Care Organizations
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To summarize the U.S. Preventive Services Task Force (USPSTF) recommendations on screening for overweight in children and adolescents and the supporting scientific evidence

TARGET POPULATION

Asymptomatic children and adolescents (aged 6 to 19 years) seen in primary care

INTERVENTIONS AND PRACTICES CONSIDERED

Considered But Not Specifically Recommended

Routine screening for overweight in children and adolescents using body mass index (BMI)

MAJOR OUTCOMES CONSIDERED

- Key Question 1: Is there direct evidence that screening (and intervention) for overweight in childhood improves age-appropriate behavioral or physiologic measures, or health outcomes?
- Key Question 2a: What are appropriate standards for overweight in childhood and what is prevalence of overweight based on these?
- Key Question 2b: What clinical screening tests for overweight in childhood are reliable and valid in predicting obesity in adulthood?
- Key Question 2c: What clinical screening tests for overweight in childhood are reliable and valid in predicting poor health outcomes in adulthood?
- Key Question 3: What are the adverse effects of screening, including labeling? Is screening acceptable to patients?
- Key Question 4: Do weight control interventions (behavioral counseling, pharmacotherapy, surgery) lead to improved intermediate outcomes, including behavioral, physiologic or weight-related measures?
- Key Question 4a: What are common behavioral and health system elements of efficacious interventions?

- Key Question 4b: Are there differences in efficacy between patient subgroups?
- Key Question 5: Do weight control interventions lead to improved health outcomes, including decreased morbidity, and/or improved functioning (school attendance, self-esteem and other psychosocial indicators)?
- Key Question 6: What are the adverse effects of interventions? Are interventions acceptable to patients?
- Key Question 7: Are improvements in intermediate outcomes associated with improved health outcomes? (Only evaluated if there is no direct evidence for Key Question #1 or Key Question #5 and if there is sufficient evidence for Key Question #4)

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic review of the literature was prepared by the Oregon Evidence-based Practice Center (EPC) and Oregon Health & Science University for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Search Strategy

The EPC developed an analytic framework and seven key questions (KQ), using USPSTF methods, to guide the literature search. They developed literature search strategies and terms for each KQ and conducted four separate literature searches (for KQs 1 and 2; for KQs 4, and 5; for KQ 3; and for KQ 6) in Medline, PsycINFO, CINAHL, and the Cochrane library, to update the literature from previous good-quality systematic reviews (KQs 4, 5, and 6) or to comprehensively examine literature from 1966 to the present (KQs 1, 2, and 3). Literature searches were extensively supplemented with source material from experts in the field, bibliographies of included trials, and other reviews. They also conducted limited hand searching of pediatric obesity-focused editions of selected journals. A single investigator reviewed abstracts. A second investigator reviewed all excluded abstracts for all KQs, except KQ2. Due to this search's large yield, EPC staff conducted blinded dual review for a random subset (27%), with acceptable agreement (97.5%) between reviewers. Inter-reviewer discrepancies were resolved by consensus.

NUMBER OF SOURCE DOCUMENTS

Using pre-specified inclusion criteria, staff from the Oregon Evidence-based Practice Center (EPC) reviewed 2,162 abstracts and 353 complete articles for Key Questions (KQs) 1 and 2, 949 abstracts and 198 complete articles for KQs 4 and

5, and 1,176 abstracts and 36 complete articles for KQs 3 and 6. They included 0 articles for KQ1, 41 articles for KQ2, 0 articles for KQ3, 22 articles for KQs 4 and 5, and 4 articles for KQ6.

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Note from the National Guideline Clearinghouse (NGC): A systematic review of the literature was prepared by the Oregon Evidence-based Practice Center (EPC) and Oregon Health & Science University for the Agency for Healthcare Research and Quality (AHRQ) for use by the U.S. Preventive Services Task Force (USPSTF) (see the "Companion Documents" field).

Article Review and Data Abstraction

One primary reviewer abstracted relevant information from included studies into standardized evidence tables. To be within the USPSTF scope, interventions needed to be conducted in primary care or feasible for primary care conduct or

referral (defined elsewhere), and were categorized as pharmaceutical, surgical, or behavioral counseling interventions. Abstracted behavioral counseling intervention details included setting, type of professional delivering the intervention, parent/family participation, intervention components, number and type of contacts, and intervention duration. Comprehensive behavioral treatments were those using a combination of behavioral modification (e.g., self-monitoring, stimulus control, cognitive-behavioral techniques), dietary modification (e.g., Traffic Light Diet, reduced glycemic load, reduced fat or kilocalorie diets), and physical activity components (broadly specified as aerobic, callisthenic, lifestyle, or decreased sedentary behaviors).

Studies had to report weight outcomes, preferably as body mass index (BMI) or BMI percentile changes, to be included. EPC staff also recorded all reported behavioral, physiological, and health outcomes specified on the analytic framework.

Literature Synthesis

There were insufficient homogeneous studies for any key question to allow quantitative synthesis. To better illustrate the study participants' degree of overweight and the treatment impact of clinical interventions on overweight, EPC staff converted baseline measures and outcomes to BMI percentiles and plotted results on the Centers for Disease Control and Prevention (CDC) growth charts. Treatment effects that were typical of interventions in this age group (10 to 20% reduction in percent overweight after one year) were modeled and plotted for 8, 10, and 12 year old girls. They plotted reported mean BMI treatment effects at 6 or more months for six trials in adolescents included in the review (one adolescent trial did not report BMI or percent overweight outcomes). These methods are described in more detail elsewhere (see "Availability of Companion Documents" field). Using the USPSTF approach, EPC staff summarized the overall quality of the evidence for each key question.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

When the overall quality of the evidence is judged to be good or fair, the U.S. Preventive Services Task Force (USPSTF) proceeds to consider the magnitude of net benefit to be expected from implementation of the preventive service. Determining net benefit requires assessing both the magnitude of benefits and the magnitude of harms and weighing the two.

The USPSTF classifies benefits, harms, and net benefits on a 4-point scale: "substantial," "moderate," "small," and "zero/negative."

"Outcomes tables" (similar to "balance sheets") are the USPSTF's standard resource for estimating the magnitude of benefit. These tables, prepared by the

topic teams for use at USPSTF meetings, compare the condition specific outcomes expected for a hypothetical primary care population with and without use of the preventive service. These comparisons may be extended to consider only people of specified age or risk groups or other aspects of implementation. Thus, outcomes tables allow the USPSTF to examine directly how the preventive service affects benefits for various groups.

When evidence on harms is available, the topic teams assess its quality in a manner like that for benefits and include adverse events in the outcomes tables. When few harms data are available, the USPSTF does not assume that harms are small or nonexistent. It recognizes a responsibility to consider which harms are likely and judge their potential frequency and the severity that might ensue from implementing the service. It uses whatever evidence exists to construct a general confidence interval on the 4-point scale (e.g., substantial, moderate, small, and zero/negative).

Value judgments are involved in using the information in an outcomes table to rate either benefits or harms on the USPSTF's 4-point scale. Value judgments are also needed to weigh benefits against harms to arrive a rating of net benefit.

In making its determinations of net benefit, the USPSTF strives to consider what it believes are the general values of most people. It does this with greater confidence for certain outcomes (e.g., death) about which there is little disagreement about undesirability, but it recognizes that the degree of risk people are willing to accept to avert other outcomes (e.g., cataracts) can vary considerably. When the USPSTF perceives that preferences among individuals vary greatly, and that these variations are sufficient to make trade-off of benefits and harms a "close-call," then it will often assign a C recommendation (see the "Recommendation Rating Scheme" field). This recommendation indicates the decision is likely to be sensitive to individual patient preferences.

The USPSTF uses its assessment of the evidence and magnitude of net benefit to make recommendations. The general principles the USPSTF follows in making recommendations are outlined in Table 5 of the companion document cited below. The USPSTF liaisons on the topic team compose the first drafts of the recommendations and rationale statements, which the full panel then reviews and edits. Recommendations are based on formal voting procedures that include explicit rules for determining the views of the majority.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations according to one of 5 classifications (A, B, C, D, I) reflecting the strength of evidence and magnitude of net benefit (benefits minus harms):

A

The USPSTF strongly recommends that clinicians provide [the service] to eligible patients. The USPSTF found good evidence that [the service] improves important health outcomes and concludes that benefits substantially outweigh harms.

B

The USPSTF recommends that clinicians provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

COST ANALYSIS

One recent study estimated that hospital costs for overweight-related disorders in children and adolescents have more than tripled in the last 2 decades based on the doubling of children hospitalized for overweight-related asthma, diabetes, sleep apnea, and gall bladder disease and on lengthened hospital stays for overweight children.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Before the U.S. Preventive Services Task Force (USPSTF) makes its final determinations about recommendations on a given preventive service, the Evidence-based Practice Center and the Agency for Healthcare Research and Quality send a draft systematic evidence review to 4 to 6 external experts and to federal agencies and professional and disease-based health organizations with

interests in the topic. They ask the experts to examine the review critically for accuracy and completeness and to respond to a series of specific questions about the document. After assembling these external review comments and documenting the proposed response to key comments, the topic team presents this information to the Task Force in memo form. In this way, the Task Force can consider these external comments and a final version of the systematic review before it votes on its recommendations about the service. Draft recommendations are then circulated for comment from reviewers representing professional societies, voluntary organizations, and Federal agencies. These comments are discussed before the whole USPSTF before final recommendations are confirmed.

Recommendation of Others. Recommendations for screening for overweight in children and adolescents from the following groups were discussed: the American Academy of Pediatrics (AAP); the Expert Committee from the Maternal and Child Health Bureau, Health Resources and Services Administration, and the Institute of Medicine (IOM).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and the quality of the overall evidence for a service (good, fair, poor). The definitions of these grades can be found at the end of the "Major Recommendations" field.

The USPSTF concludes that the evidence is insufficient to recommend for or against routine screening for overweight in children and adolescents as a means to prevent adverse health outcomes. I recommendation

Approximately 15% of children and adolescents aged 6 to 19 years are overweight and are at risk for diabetes, elevated blood lipids, increased blood pressure and their sequelae, as well as slipped capital femoral epiphysis, steatohepatitis, sleep apnea, and psychosocial problems. The USPSTF found fair evidence that body mass index (BMI) is a reasonable measure for identifying children and adolescents who are overweight or are at risk for becoming overweight. There is fair evidence that overweight adolescents and children aged 8 years and older are at increased risk for becoming obese adults. The USPSTF found insufficient evidence for the effectiveness of behavioral counseling or other preventive interventions with overweight children and adolescents that can be conducted in primary care settings or to which primary care clinicians can make referrals. There is insufficient evidence to ascertain the magnitude of the potential harms of screening or prevention and treatment interventions. The USPSTF was, therefore, unable to determine the balance between potential benefits and harms for the routine screening of children and adolescents for overweight.

Clinical Considerations

- It is important to measure and monitor growth over time in all children as an indicator of health and development. The number of children and adolescents who are overweight has more than doubled since the early 1970s, with the

prevalence of overweight (BMI = 95th percentile for age and sex) for children aged 6 to 19 years now at approximately 15%. The conclusion that there is insufficient evidence to recommend for or against screening for overweight in children and adolescents reflects the paucity of good-quality evidence on the effectiveness of interventions for this problem in the clinical setting. There is little evidence for effective, family-based or individual approaches for the treatment of overweight in children and adolescents in primary care settings. The Centers for Disease Control and Prevention's (CDC's) Guide to Community Preventive Services has identified effective population-based interventions that have been shown to increase physical activity, which may help reduce childhood overweight.

- BMI (calculated as weight in kilograms divided by height in meters squared) percentile for age and sex is the preferred measure for detecting overweight in children and adolescents because of its feasibility, reliability, and tracking with adult obesity measures. BMI values are CDC population-based references for comparison of growth distribution to those of a larger population. Being at risk for overweight is defined as a BMI between the 85th and 94th percentile for age and sex, and overweight as a BMI at or above the 95th percentile for age and sex. Disadvantages of using BMI include the inability to distinguish increased fat mass from increased fat-free mass, and reference populations derived largely from non-Hispanic whites, potentially limiting its applicability to non-white populations. Indirect measures of body fat, such as skinfold thickness, bio-electrical impedance analysis, and waist-hip circumference, have potential for clinical practice, treatment, research, and longitudinal tracking, although there are limitations in measurement validity, reliability, and comparability between measures.
- Childhood overweight is associated with a higher prevalence of intermediate metabolic consequences and risk factors for adverse health outcomes, such as insulin resistance, elevated blood lipids, increased blood pressure, and impaired glucose tolerance. Severe childhood overweight is associated with immediate morbidity from conditions such as slipped capital femoral epiphysis, steatohepatitis, and sleep apnea. Medical conditions new to this age group, such as type 2 diabetes mellitus, represent "adult" morbidities that are now seen more frequently among overweight adolescents. For most overweight children, however, medical complications do not become clinically apparent for decades.

Definitions:

Strength of Recommendations

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The USPSTF recommends that clinicians provide [the service] to eligible patients. The USPSTF found at least fair evidence that [the service] improves important health outcomes and concludes that benefits outweigh harms.

C

The USPSTF makes no recommendation for or against routine provision of [the service]. The USPSTF found at least fair evidence that [the service] can improve health outcomes but concludes that the balance of benefits and harms is too close to justify a general recommendation.

D

The USPSTF recommends against routinely providing [the service] to asymptomatic patients. The USPSTF found at least fair evidence that [the service] is ineffective or that harms outweigh benefits.

I

The USPSTF concludes that the evidence is insufficient to recommend for or against routinely providing [the service]. Evidence that [the service] is effective is lacking, of poor quality, or conflicting and the balance of benefits and harms cannot be determined.

Strength of Evidence

The U.S. Preventive Services Task Force (USPSTF) grades the quality of the overall evidence for a service on a 3-point scale (good, fair, poor):

Good

Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes.

Fair

Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes.

Poor

Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of evidence supporting the recommendations is identified in the "Major Recommendations" field.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate screening for overweight in children and adolescents

POTENTIAL HARMS

There is insufficient evidence on the harms of screening. Potential harms include labeling, induced self-managed dieting with negative sequelae, poor self-concept, poor health habits, disordered eating, or negative impact from parental concerns. These theoretical harms are inferred from studies of limited design. There also is insufficient evidence on the harms of interventions. Among 4 recent behavioral intervention trials, adverse effects were reported in 1 trial. Among those who completed an intervention (37/44) in a good-quality randomized controlled trial (RCT) in a primary care setting, no problematic eating was detected in the adolescent participants after treatment. During the placebo-controlled phase of the sibutramine trial, 19 of 43 patients (44%) in the group receiving sibutramine had their dosage reduced or discontinued because of elevated blood pressure, pulse rate, or both. No other adverse events were reported.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Recommendations made by the U.S. Preventive Services Task Force are independent of the U.S. Government. They should not be construed as an official position of the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

Limitations of the Literature

In the absence of direct evidence of screening's impact on improved weight and health outcomes in children and/or adults, staff from the Oregon Evidence-based Practice Center (EPC) evaluated indirect evidence for screening and intervention. In the current literature, evidence linkages between screening and intervention are hampered by divergent definitions of overweight. It is important that a consistent definition of overweight be accepted to encourage rapid progress in the understanding of how to address this critical problem.

Limited evidence on normal body composition in children and adolescents, and lack of criterion standards for adiposity in children, hampered the EPC staff's ability to determine the test characteristics (sensitivity and specificity) of clinically feasible screening tests. Valid, feasible body composition measures in children are becoming established, which should allow the examination of sensitivity and specificity of body mass index (BMI) percentiles and overweight in U.S. populations, as elsewhere. Similarly, clearly establishing current or future health consequences of elevated BMI (and other overweight measures) for boys and girls of all ages and racial/ethnic origins will enable future diagnostic research. By confining the review of childhood BMI and adult health consequences to longitudinal U.S. studies, EPC staff gained some advantages from more similar overweight definitions, measurements, and reference standards, but may have unnecessarily eliminated applicable data. Since the reviewed research was primarily in non-Hispanic whites, its applicability to minorities, in whom the prevalence of overweight is particularly increasing, may be limited.

EPC staff did not locate adequate longitudinal data relating childhood weight status to childhood health outcomes, and thus did not review it formally. Current literature is primarily cross-sectional, presents relative risks without absolute risks, or reports on the relationship of growth measures (or changes in them over time) to intermediate measures, such as blood pressure or lipids, rather than health outcomes.

Although an effort was made to comprehensively review several areas of the literature, some areas were not reviewed. EPC staff did not review any evidence on children under the age of two, although this is an active area for research. They did not attempt to examine risk factors for childhood overweight, but note that others have recently done so. Similarly, research on changing children's daily life habits that might also affect or prevent pediatric overweight—such as changing dietary intake, increasing physical activity or limiting activities such as television viewing—that did not directly address weight effects were beyond their scope.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence

about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size Guide to Clinical Preventive Services.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Pocket Guide/Reference Cards
Tool Kits

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force (USPSTF). Screening and interventions for overweight in children and adolescents: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2005. 11 p. [39 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005 Jul

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

SOURCE(S) OF FUNDING

Agency for Healthcare Research and Quality

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Corresponding Author: Ned Calonge, MD, MPH, Chair, U.S. Preventive Services Task Force (USPSTF), c/o Program Director, USPSTF, Agency for Healthcare Research and Quality

Task Force Members*: Ned Calonge, MD, MPH, Chair, USPSTF (Acting Chief Medical Officer and State Epidemiologist, Colorado Department of Public Health and Environment, Denver, CO); Janet D. Allan, PhD, RN, CS, Vice-chair, USPSTF (Dean, School of Nursing, University of Maryland Baltimore, Baltimore, MD); Alfred O. Berg, MD, MPH, (Professor and Chair, Department of Family Medicine, University of Washington, Seattle, WA); Paul S. Frame, MD (Family Physician, Tri-County Family Medicine, Cohocton, NY, and Clinical Professor of Family Medicine, University of Rochester, Rochester, NY); Joxel Garcia, MD, MBA, (Deputy Director, Pan American Health Organization, Washington, DC); Russell Harris, MD, MPH (Professor of Medicine, Sheps Center for Health Services Research, University of North Carolina School of Medicine, Chapel Hill, NC); Mark S. Johnson, MD, MPH (Professor and Chair, Department of Family Medicine, University of Medicine and

Dentistry of New Jersey-New Jersey Medical School, Newark, NJ); Jonathan D. Klein, MD, MPH (Associate Professor, Department of Pediatrics, University of Rochester School of Medicine, Rochester, NY); Carol Loveland-Cherry, PhD, RN (Executive Associate Dean, Office of Academic Affairs, University of Michigan School of Nursing, Ann Arbor, MI); Virginia A. Moyer, MD, MPH (Professor, Department of Pediatrics, University of Texas Health Sciences Center, Houston, TX); C. Tracy Orleans, PhD (Senior Scientist, The Robert Wood Johnson Foundation, Princeton, NJ); Albert L. Siu, MD, MSPH (Professor and Chairman, Brookdale Department of Geriatrics and Adult Development, Mount Sinai Medical Center, New York, NY); Steven M. Teutsch, MD, MPH (Executive Director, Outcomes Research and Management, Merck & Company, Inc., West Point, PA); Carolyn Westhoff, MD, MSc (Professor of Obstetrics and Gynecology and Professor of Public Health, Columbia University, New York, NY); and Steven H. Woolf, MD, MPH (Professor, Department of Family Practice and Department of Preventive and Community Medicine and Director of Research, Department of Family Practice, Virginia Commonwealth University, Fairfax, VA)

*Members of the USPSTF at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members and evidence-based practice center (EPC) staff disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members and EPC staff with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

From: Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Whitlock EP, Williams SB, Gold R, Smith PR, Shipman SA. Screening and interventions for childhood overweight: a summary of the evidence for the U.S. Preventive Services Task Force. Portland (OR); Agency for Healthcare Research and Quality (AHRQ); 2005. 130 p.
- Screening for overweight in children and adolescents: where is the evidence? A commentary by the Childhood Obesity Working Group of the U.S. Preventive Services Task Force. Rockville (MD); Agency for Healthcare Research and Quality (AHRQ); 2005. 6 p.
- Whitlock EP, Williams SB, Gold R, Smith PR, Shipman SA. Screening and interventions for childhood overweight: systematic evidence synthesis. Portland (OR); Agency for Healthcare Research and Quality (AHRQ); 2005. 31 p.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site.

Background Articles:

- Woolf SH, Atkins D. The evolving role of prevention in health care: contributions of the U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):13-20.
- Harris RP, Helfand M, Woolf SH, Lohr KN, Mulrow, CD, Teutsch SM, Atkins D. Current methods of the U.S. Preventive Services Task Force: a review of the process. Methods Work Group, Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):21-35.
- Saha S, Hoerger TJ, Pignone MP, Teutsch SM, Helfand M, Mandelblatt. The art and science of incorporating cost effectiveness into evidence-based recommendations for clinical preventive services. Cost Work Group of the Third U.S. Preventive Services Task Force. Am J Prev Med 2001 Apr;20(3S):36-43.

Electronic copies: Available from the USPSTF Web site.

The following are also available:

- The guide to clinical preventive services, 2005. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2005. 192 p. Electronic copies available from the AHRQ Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The Interactive Preventive Services Selector tool, which enables users to search USPSTF recommendations by patient age, sex, and pregnancy status, is available as a web-based version or PDA application. It is available from the AHRQ Web site.

PATIENT RESOURCES

The following is available:

- The pocket guide to good health for adults. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003.

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site. Copies also available in Spanish from the USPSTF Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

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